

INPATIENT TREATMENT RECORD COVER SHEET (For Plate Imprinting)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (Excluding Items 25 & 26)		LINE	LEGEND	ADMISSION REMARKS
		1	REGISTER NO. - NAME - GRADE	
		2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PRE- VIOUS ADMISSION	
		3	FMP - SSN - ORGANIZATION - WARD	
		4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE	
		5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF AD- MISSION - CLINIC SVC	
		6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
25. TYPE DISPOSITION	26. DATE OF DISPOSITION	8	NAME & LOCATION OF MEDI- CAL TREATMENT FACILITY DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
31. SELECTED ADMINISTRATIVE DATA				
<div style="text-align: right;"><input type="checkbox"/> CHECK IF CONTINUED ON REVERSE</div>				
33. CAUSE OF INJURY				
34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES				
<div style="text-align: right;"><input type="checkbox"/> CHECK IF CONTINUED ON REVERSE</div>				
35. TOTAL DAYS THIS FACILITY				
a. ABSENT SICK DAYS _____	b. OTHER DAYS _____	c. CONV LV/COOP CARE DAYS _____	d. SUPPLEMENTAL CARE DAYS _____	e. BED DAYS _____
f. TOTAL SICK DAYS _____				
36. TOTAL DAYS ALL FACILITIES				
a. ABSENT SICK DAYS _____	b. OTHER DAYS _____	c. CONV LV/COOP CARE DAYS _____	d. SUPPLEMENTAL CARE DAYS _____	e. BED DAYS _____
f. TOTAL SICK DAYS _____				
SIGNATURE OF ATTENDING MEDICAL OFFICER			SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER	

